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ABSTRACT

Until recently, understanding about women's health has been traditionally mediated by the medical model, which tends to regard each health problem in a vacuum. Such an approach ignored important considerations, such as body image. In an effort to explore this health factor, a review of the literature regarding women's health and its relation to body image is presented here. The paper examines the concept of women's body image, including the obsession with thinness, the beauty myth, media impact, the commodification and objectification of women, pornography, the rape myth, women's self-worth, and multicultural differences in body image. The desire to be thin is rampant in U.S. society and the next section examines eating disorders and body image. Some of the issues covered include: the epidemiology and etiology of eating disorders and their pervasiveness on college campuses. Sexual violence is also a growing problem and some of the factors associated with this statistic, such as the rape trauma syndrome and coping with sexual violence, are discussed. Another contextual problem connected to body image is substance abuse, particularly the abuse of alcohol, as well as depression, anxiety, and sexuality. Some practice implications for counselors in how to address these various issues are outlined. (RJM)

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Dieting, Dating and Denial: Whose Body Is It?

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Dieting, Dating and Denial: Whose Body Is It?

Overview

Until recently, our understanding of women's health — and subsequently the subdiscipline of college women's health — has traditionally been mediated by the medical model, which tends to regard each presenting health problem in a vacuum, and considers various aspects of health divorced from each other. As such, treatment and prevention modalities have oftentimes proven ineffective, in large part because they do not address the entire context within which any specific health problem manifests itself. In contrast, the wellness model regards health as a holistic, interrelated phenomenon comprised of the following seven dimensions: (1) physical; (2) emotional; (3) social; (4) intellectual; (5) spiritual; (6) environmental; and (7) occupational (Hettler, 1980). This paradigm provides a more comprehensive perspective on women's health, and suggests important implications for primary, secondary and tertiary prevention on the college campus.

Based on practice and research, it is clear that college women's health constitutes an extensive array of physical, psychological and cultural issues, including, but not limited to: alcohol, tobacco and other drug abuse; anxiety, depression and suicide; eating disorders, weight management and excessive exercise; premenstrual syndrome; sexually transmitted diseases, HIV infection and safer sex negotiation; unplanned pregnancy and effective contraceptive practices; and violence, including battering, incest and sexual assault.

Body image affects women's health in a way that is unique and different from that of men. An underlying premise of this paper is that **body image is a unifying and underlying theme undergirding all of the health issues college women grapple with**. *Body image* is defined by the authors as the beliefs about one's own attractiveness, sexuality and physical characteristics, as well as the perceptions of how others view one's own body, coupled with the inseparable emotions and cognitions which result from such beliefs and perceptions. The authors also recognize that body image is context-bound and culturally-derived.

If our goal as health educators is to create behavior change toward a healthier lifestyle in our students, we will be ineffective with the women in our population if we don't first investigate issues of body image. We cannot expect women to adopt self-caring behaviors if they do not first accept their own bodies as being worthy of being cared for. Through a better understanding of how body image affects women's health, practitioners can develop more cohesive and proactive approaches for influencing body image awareness and combating its negative impact on women's health.

The following paper is a review of the existing literature regarding women's health and

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issues related to body image. In addition, the authors provide insights and observations based on their experiences at a large, public Research I university in the South. One of the practitioners is a generalist and the other is a nutritionist; together, they provide collaborative and cross-disciplinary health promotion and intervention services for women in both individual and group settings.

Understanding Body Image

Women arrive on our campuses with their body images firmly implanted in their heads. The body images they possess are the result of a complex multitude of psychological, social and cultural factors. What consistently emerges when examining women's body image is the conflict between what women are expected to look like and what is physically and psychologically healthful for women. Body image is at the core of women's self-dissatisfaction and low self-esteem, and it is clearly related to a wide array of self-destructive behaviors.

Body image difficulties are often rooted in the earliest years of life and reflect failures in the process of separating from the family of origin in an age-appropriate manner and attaining autonomous functioning. Media and cultural images that little girls are exposed to begin defining female beauty from that tender age. Sadly, studies show that self esteem of girls plummet when they reach adolescence; this doesn't happen to boys. Early sexual activity during adolescence can cause harm; if a girl is naked and having sex, and her partner makes a comment about her body fat, the effects can be devastating. Similarly, one of the most critical periods when women need positive feedback is during the transition time which marks leaving home for college. This transition frequently coincides with the point at which people with body image problems begin to have real difficulty.

When women place so much importance on body image, they have less energy to invest in developing unique competencies as professionals, students, parents, partners, or friends. Yet, this self-absorbed investment in the body may also mask a deeper dread of examining the self honestly. Through obsession with her physical self, a woman can often avoid facing difficult questions of life, as well as successfully avoid self-scrutiny in the areas of emotional, social and spiritual development. Similarly, investment in one's body to the exclusion of others serves the defensive purpose of avoiding connection or dependency on others. However, the reality of life is that we all need other people, particularly in times of stress or change.

The Obsession with Thinness. Studies show that nine out of 10 females dislike their bodies. When surveyed, 75% of women (compared to 54% of men) say that they often think about their physical appearance and would prefer that their bodies were different. More specifically, 78% are dissatisfied with their weight, while 35% would like to lose 25 pounds or more. On college campuses, sorority women, female chemical engineering majors, star athletes on the swim team, nontraditional students, and women's rights activists all report greater dissatisfaction with their bodies as compared to their male peers.

It has been estimated that 90%of women have dieted at one time or another, while 50% are

on a diet at any one time. When asked to estimate their weight, 90% say they are overweight, even though only 45% are actually overweight -- the same rate as among men.

Women are socialized beginning at an early age to prefer thinness as the ideal body image. Over 700 million Barbie dolls have been sold in the U.S., despite the fact that if Barbie were a real woman, her projected measurements would be 36-18-33 -- and she wouldn't have enough fat to have menstrual periods. In one study, 80% of 3- to 5-year-olds chose to play with a thin doll instead of a heavy one, saying the thin doll was more fun. This preference is alarming given studies that indicate that a girl needs approximately 17% body fat in order for menarche to occur. To continue having periods, one researcher has suggested that a 22% body fat was needed (Frisch, 1985). Body fat charts often indicate women as having "excellent" body fat if she is below a certain level, for instance 20% or below.

The "Beauty Myth." Women's distorted body image extends beyond a concern with weight and size. Our society's notions about female beauty and femininity are intricately woven into the fabric of body image. Naomi Wolf (1991) has observed that as women have made political, economic and educational advances in this country, the more strictly, heavily and cruelly have images of female beauty been imposed on them. Says Wolf, "We are in the midst of a violent backlash against feminism that uses images of female beauty as a political weapon against women's advancement: the beauty myth" (p. 10). In addition, "The qualities that a given period calls beautiful in women are merely symbols of the female behavior that period considers desirable: *The beauty myth is always actually prescribing behavior and not appearance*" (Wolf, 1991, pp. 13-14).

The beauty myth falsely suggests that the quality called "beauty" objectively and universally exists, that women seek to embody that beauty, and that men want to possess women who embody it. However, anthropology demonstrates that beauty clearly is not a universal or everlasting concept; its embodiment has varied tremendously over time and across cultures. Furthermore, beauty is "a currency system like the gold standard. Like any economy, it is determined by politics, and in the modern age in the West it is the last, best belief system that keeps male dominance intact. In assigning value to women in a vertical hierarchy according to a culturally imposed physical standard, it is an expression of power relations in which women must unnaturally compete for resources that men have appropriated for themselves" (Wolf, 1991, p. 12).

The beauty myth, because it prescribes thinness as one of its tenets, has generated a weight-obsessed and diet-crazed population of women. Hunger and guilt associated with food have become endemic in the female condition. Yet, hungry women think poorly and feel incompletely. Says Wolf (1991), "Hunger makes women's bodies hurt them, and makes women hurt their bodies" (p. 218). The beauty myth confuses physical attractiveness with health, normalizes pain as healthy, or ignores women's pain, or equates pain with beauty.

A corollary of the beauty myth is the *professional beauty qualification* (PBQ), which circumscribes certain expectations for women's appearance in order for them to succeed or advance in the workplace; in other words, women's intellectual worth and professional

competence is actually judged by their physical beauty. As a result, each woman is expected to expend resources, time and energy in beauty maintenance — time, energy and resources that could otherwise be devoted to her career.

The beauty myth, claims Wolf, has created some powerful industries — the $33 billion a year diet industry, the $20 billion cosmetic industry, the $300 million cosmetic surgery industry, and the $7 billion pornography industry. All of these industries have capitalized on the insecurities and anxieties generated in women by the beauty myth. The myth holds out to women a standard that is inherently impossible to achieve, generating an endless cycle of dissatisfaction and consumerism.

Furthermore, the implications of the beauty myth are not just economic ones. Violence against women is related to the beauty myth; the myth portrays women as passive objects subject to the sexual and physical whims of men. It places women in the indefensible position of being simultaneously virgin and whore: she must be beautiful in order to be desirable, yet her beauty increases her vulnerability to rape and is used to justify her violation. Women's ability to experience their own sexuality to the fullest extent is crippled by the beauty myth; women's genitals and bodies are eroticized for men, not for women, and that eroticization takes place under men's control, not women's. Women are taught how to look sexual, but are not taught how to experience their own sexuality. Women's masturbation is normalized for men's pleasure, but not for her own. In addition, the beauty myth equates sex with love and intimacy for women (Wolf, 1991)..

The Impact of Media. The mass media is one of the most influential forces in U.S. society. Through books, newspapers, magazines, movies, music television videos, compact discs, billboards, pornography commercials — and now the Internet, corporate entities can promote, generate, or maintain our cultural norms and social mores. No aspect is more persuasive than advertising in defining our idea of beauty. In fact, advertising is a $100 billion a year industry. In 1988, advertisers spent approximately $500 per person to ensure that every man, woman and child is exposed to over 1,600 ads per day. An estimated 99.5% of American households have a TV set which is turned on an average of six hours and 20 minutes per day, exposing the average person to 18,000 commercials per year. A.C. Nielsen figures indicate that the average U.S. citizen will spend over seven years of his or her life in front of a television set; the amount of television viewing is increasing rapidly among children and adolescents. In fact, advertising executives depend on the ability of TV images to implant themselves in peoples' minds, remain there, and cause them to imitate the characters and behaviors in commercials.

A subset of mass media which reinforces unhealthy body image is the fashion and modeling industry. Trends on the runway and in clothing design create a beauty ethic that is not achievable for the majority of women. Less than 5% of the population has the runway model-like body type: tall, long- legged, small-waisted and broad shouldered. You are either born with this body type or you're not; you cannot diet yourself into it. Yet , the average model is 23% slimmer than the average American woman; she is probably 5'9" tall, and weighs 110 pounds. A generation ago, she was 8% less. In contrast, today's average woman is 5'4" tall and weighs an average of 142 pounds.

Female bodies haven't changed -- only the ideal has. During the 1950's and 1960's, the sample dress size was a 12 (average). Today, regular dress sizes end at 12 or 14, despite the fact that 33% of American women wear a size 16 or larger. Store mannequins have on the order of 10% body fat. While only 27% of American women are overweight, 44% of them are "trying to lose weight." Since 1960, each year's Miss America winner got thinner, but the average young adult woman got heavier.

In less than a decade, the dieting industry doubled its gross income to over $33 billion a year; today, it is over $50 billion. Sadly, the onset of dieting is occurring at earlier and earlier ages, as well. In fact, one study found that 50% of nine year-old girls and 80% of 10 year-old girls had already dieted (even though only 15% of these girls were overweight) (Eating Disorders Awareness and Prevention, Inc., 1994).

Commodification and Objectification of Women. Beyond promoting standards of beauty, the mass media impacts women's body image in another important way. From an early age, both males and females are taught to regard women's sexuality as a commodity and to view women's bodies as objects. Their commodification and objectification results in serious ramifications for women's safety and well-being, and severely impairs women's abilities to regard their bodies as connected, holistic entities deserving of care and respect. Indeed, the mass media has profited tremendously through a conscious campaign of denigrating women's bodies.

The largest offending culprit in the commodification an objectification of women is pornography, and industry which generates in excess of $7 billion a year, grossing more in one year than the film and music industries combined. There are four times as many pornographic bookstores in the U.S. as there are McDonalds, and **Playboy** and **Penthouse** outsell **Time** and **Newsweek** ten to one on the newsstand.

Pornography is defined as writing or imagery that objectifies, degrades, and brutalizes a person in the name of sexual stimulation or entertainment. The root of the word "pornography" is *porne*, which means the graphic depiction of female sexual slavery. It can also be defined as the sexually explicit subordination of women, graphically depicted in either pictures or words, in which women are presented in one or more of the following ways: (1) as dehumanized sexual objects, things or commodities; (2) as enjoying pain and humiliation or experiencing pleasure in being raped; (3) tied up, cut up, mutilated, bruised, or physically hurt; (4) in postures of sexual submission or servility; or (5) as body parts such that women are reduced to those parts (University of Massachusetts at Amherst, Everywomen's Center, 1990).

By its definition, pornography includes a wide range of materials: advertisements, pulp novels, romance novels, comics, drugstore detective and science fiction magazines, soft core porn, and hard core porn. Slasher films, in which a sexually arousing image precedes a brutal death scene, and "snuff" films, which record an actual rape and murder of a woman (usually a prostitute), are especially disturbing genres of pornography and media. Increasingly, the images of pornography are being subtly and even blatantly duplicated in mainstream media; sexually degrading images of women, as well as portrayals of violence against women, are being used with greater frequency to sell products ranging from beer and liquor, to clothing and cosmetics. *As a*

whole, these uses of some women bodies translates into the commodification of all women.

What alarms feminists like Andrea Dworkin and Catherine MacKinnon is not the sexual explicitness, but rather the promulgation of degrading images of women and the increasing violence and degree of violence that have appeared in pornography since the 1970's. Says Dworkin (1981), "Male power is the raison d'etre of pornography; the degradation of the female is a means of achieving this power" (p. 25). Pornography not only fuses sex with violence, but imparts the false notion that sexual violence has positive outcomes for the individuals involved.

The images in mainstream media are just as harmful and damaging as those in pornography, if not more so. Whereas moral conscience and obscenity laws regulate where and when pornography can be shown, commercial product advertising, for example, masquerades as art, marketing, fashion – anything but pornography. Therefore, their images appear unrestricted on the streets, on television, in stores, in theaters and in magazines under the guise that their content is non-offensive. *However, an image is defined as pornography not by its location or content, but by its context.* An ad selling perfume is no different than the centerfold of **Hustler** if the women appearing in both are similarly sexualized and objectified.

Ciriello (1993) discusses the harmful effects of the pornography industry filtering into the entertainment, leisure and service industries on women's lives. She argues that these industries, along with the cooperation of mass media, (1) sexualize women's labor, (2) condone and contribute to sexual harassment, and (3) put real women in danger. Women have become the entertainment, and they are entertaining men (e.g., Playboy pinball machine, national "breastaurant" chains such as Hooters, Mugs & Jugs, Melons, and Knockers, $3 billion a year topless industry, "quality" strip clubs such as Gold Club in Atlanta, Men's Club in Houston, and Solid Gold in Minneapolis). Says Ciriello, "Companies that conduct business meetings, luncheons, or dinners at topless and strip clubs need to realize that expense-accounting their employees' participation at these clubs sends a confusing message to all their employees. At a time when companies are adopting policies that address the serious issue of sexual harassment in the workplace, they are communicating that it's all right to treat women as sex objects during the course of business entertainment" (p.273).

Clearly, one of the most serious consequences of mass media on norms regarding women's body image is the generation of a "rape culture," captured in "rape myths." Those attitudes, beliefs and values which essentially justify rape, as well as place the blame for rape on the victim, can be referred to collectively as "rape myths," first identified by Martha Burt. "Rape myths" are defined as **prejudicial, stereotyped or false beliefs about rape, rape victims or rapists which have the effect of denying that acts of sexual coercion are rape**. Examples of rape myths include, "If a woman leads a man on, then she deserves to be raped," "If she really didn't want it, she would have fought back harder," "A woman can't be raped if she has had sex with lots of men," or "Men rape because they can't control themselves sexually." When invoked in the courts of law, in the system of medical care, or in schools and in churches, rape myths reduce the seriousness of sexual violence, and thereby invalidate the experiences of women who are raped.

What is especially disturbing about rape myths is how early we acquire them. Sadly, **both**

boys and girls are socialized to believe rape myths beginning early in life. In a 1988 study of adolescent youth, 56% of girls and 76% of boys believe forced sex is acceptable under certain circumstances. For instance, if "he spends a lot of money on her" during a date, 39% of the males and 12% of the females said forced sex would be justified. Similarly, if "she's led him on" sexually, 54% of boys and 27% of girls believed forced sex was acceptable (Goodchilds, et.al., 1988, as cited by White & Humphrey, 1991). Another survey of 1,700 11-14 year olds conducted by the Rhode Island Rape Crisis Center in 1988 found that 31% of the boys and 32% of girls said it was okay for a man to rape a woman who had past sexual experiences, while 65% of the boys and 47% of the girls believed it was okay for a man to rape a woman if they had been dating for more than six months (White & Humphrey, 1991).

Women's Self-Worth. As a result of the media, sex-role socialization, and other cultural and societal forces, we are raising generations of women who have encoded their self-esteem into the number of fat grams they consume and the size of the jeans they where. Similarly, women's self-worth is determined by the extent to which they adhere to the prevailing standards of beauty — standards which all women would find impossible to fulfill, but are especially difficult for women of color to achieve. Finally, women as a whole are being taught that their bodies are not their own to control; rather, women's bodies have become equated with the products they are used to sell — indeed, women's bodies have become the product being sold. It is not that women's sexuality or femininity should not be realized; rather, women's justification for existence has been reduced to their sexuality and femininity.

Numerous studies have reported that women's body image satisfaction is more highly correlated with self-esteem than that of men. Men, for the most part, view their bodies as functional and active; a man tends to feel satisfied as long as his body is healthy and working well. Women are prone to feel good about their bodies only if they are aesthetically pleasing to themselves and others. Consequently, if a women feels less attractive than her male counterpart, her sense of self worth will be lower.

It is important to remember that women are not biologically programmed to equate self-worth with having a certain body type. Sexualized, commodified, and objectified, it is no wonder that women's images of their own bodies have become so distorted. These are attitudes, beliefs and behaviors that we learn from our parents, our friends, our teachers, the media — even in church. We have arrived at a point where the very essence of femininity is defined by size and appearance; simultaneously, women are learning that their femininity — or lack thereof in society's eyes — defines their self-worth and their identity as women.

The idea of feminine beauty has varied considerable over the centuries. Of late, we seem to be immersed in a symptomatic sea of disordered eating among all women. Women's magazines tout the advantages of the latest fad diets side by side with pages of luscious recipes. The paradoxical message-to remain slender while still partaking of life's succulent smorgasbord-presents an immediate, albeit rather superficial conflict: to indulge or to remain slender in the face of great abundance.

Our society evaluates and admires men for their vocation — what they accomplish and

what they achieve. Women are usually evaluated by and accepted for how they look, regardless of what they do. A woman can be incredibly successful and still find that her beauty or lack of it will have more to do with her acceptance than what she is able to accomplish. From the time they are tiny children, most females are taught that beauty is the supreme objective in life. The peer pressure for girls in school to be skinny is often far greater than for boys to make a team. It is as if when a boy hits puberty, he thinks, "I'm getting stronger." A girl thinks, "I'm getting fat."

A consequence of connecting body size with self-worth is that the differential treatment on the basis of size — of all individuals, but of women in particular — is perhaps the last form of discrimination that is culturally and socially accepted in the U.S. This reality was well-documented by a 20/20 investigation team from ABC television. In fact, overweight females are 40% less likely to go to college, are 20% less likely to marry, make on average $6,700 less per year than other women, and are more likely to be found guilty by a jury. Observes Pat Lyons, "If shame could cure obesity there wouldn't be a fat woman alive."

Multicultural Differences in Body Image. In general, body image-related issues affect all women in some way, even though the specific manifestation of these issues does certainly vary across different racial/ethnic groups, by sexual orientation, and by age. The role that culture has in the development of body image is tremendous. For example, in cultures where plumpness is valued, eating disorders are rare. We examine body image as it specifically affects two cultural groups: African American women and Asian American women.

African American students have fewer eating difficulties than white students. Only 3% of African American women, as compared to 13% white women, meet criteria for bulimia. Conversely, of all ethnic groups, African American women have the highest incidence of obesity: 49.2% (by age 45). Similarly, the most likely segment of the population to gain weight is black females ages 25-34. Therefore, a wide variety of health problems associated with obesity — including diabetes and heart disease — are more common among African American women.

Yet, 40% of African American women who are overweight still view their bodies as attractive, and almost 100% of them report no negative effects of being overweight on their personal or family relationships. A 1995 study conducted by researchers at the University of Arizona found that African American adolescent females are seven times as likely to be content with their bodies than white adolescents, and 70% of African American teenage girls are satisfied with their bodies. Researchers believe the reason for this is the strong communicative relationship African American mothers and daughters have. Mothers are viewed as powerful role models and wise, beautiful matriarchs. In addition, the definition of beauty for African American women goes far beyond thinness. Therefore, while white women may need to weigh 117 to feel attractive, a black woman could weigh 145 and view herself as physically and sexually desirable. African American women's bones are denser and they have more muscle mass, making extra pounds perfectly fine.

However, one of the authors who provides nutritional counseling on a regular basis reports seeing more African American women present with concerns about their weight. According to

a 1993 survey conducted by **Essence** magazine, 54% of black women are at risk for developing an eating disorder. This is perhaps not so surprising given the use of African American models whose size, shape and features adhere to mainstream concepts of female beauty. Many middle-class blacks who are assimilated into the white culture want to be thin.

Additionally, the issue of racism affects body image of women of color. For example, white racism may be internalized by African American students, who in turn learn to regard their facial features, coloring, hair texture, etc. as unappealing. One of the authors has encountered a substantial amount of dissatisfaction among African American women with their looks; many feel the pressure to use chemical products to alter both their skin color and hair texture. Preliminary observations indicated that issues of body image and femininity induce a high level of stress and anxiety among African American women. The impact of beauty ideals on African American women clearly necessitates further study.

Similarly, Asians demonstrate a low physical self-concept, given the predominant and unattainable standards of beauty in the mainstream culture. Studies have found that Asian American females are more dissatisfied with their bodies than their white counterparts. Eating disorders as one manifestation of poor self-concept among Asian Americans has been the subject of some study. Preliminary findings indicate that eating problems are significantly more prevalent among Asians women than white women. In another study of college-age women, Lucero, et.al. (1992) initially found that there was no significant difference in symptomology of eating problems between Asian and white women. However, while 60% of Asian women and 57% of Caucasian women were found to have symptoms of disordered eating, Caucasian women were 5.5 times more likely to self-report an eating problem. Under reporting, particularly among Asian-Americans, conceivably contributes to an underestimation of health problems in this population.

Eating Disorders and Body Image

Of all the health issues which explicitly affect women, eating disorders perhaps has a relationships with body image that is most readily understood. Research has shown that dieting and self-starvation are strong predictors of the eating disorders in women; it is clear that the beauty myth and other pressures to conform to a restricted ideal of femininity impinge on the obsession with thinness which plagues adolescent girls and women.

Epidemiology of Eating Disorders. Because of the secrecy that tends to surround eating disorders, it is difficult to know just how common this condition is. However, numerous research surveys have indicated that anywhere from 1-5% of the female population is anorexic, and 2-15% is bulimic — while as many as 30% of college females are bulimic. In addition, 86% of bulimics are between the ages of 15 and 30, and 30% of bulimics report a previous history of anorexia (National Institute of Mental Health, 1993).

Eating disorders are rampant in junior and senior high schools as well as on college campuses. It is most prevalent in so-called managerial-professional families, while currently the incidence is much lower in blue collar families. Eating disorders can begin at any time between the

ages of 10-30; the peak for onset is ages 11-15 in women. Anorexia is most likely to present itself at ages 12-13 and 19-20 (American Dietetic Association, 1996), while most individuals presenting for therapy are in their 20's or 30's. Anorexics are characterized by extreme emaciation (below 15%f healthy weight) achieved through a variety of means, including self-starvation, purging and excessive exercise. About 75% end up in hospital. Bulimics are characterized by cycles of binge eating and purging, at least twice a week during a three month period. Laxative use is the most harmful method utilized by bulimics to purge.

Kim Chernin (1986) in **The Hungry Self: Women, Eating and Identity** suggests that at least half the women on campuses in the U.S. suffer at some time from bulimia or anorexia. She interprets bulimia as a religious rite of passage for women, signifying their separation from mother as the nurturer and feeder. One might presume that in a university where women are supposed to be liberated and educated that eating disorders would be less common, yet many of the students the authors see are activists in promoting women's issues and are tremendously annoyed with themselves for falling into the trap of striving for society's ideal. As our culture continues to connect thinness to success, we will continue to have eating disorders -- and the pressure to be successful is perhaps no where as strong as it is for females in college today. Thus, we literally have an epidemic of eating disorders on campus.

Eating disorders are perhaps more prevalent among college women than any other group—with the exception of certain types of female athletes. There are numerous explanations for this. First of all, food is everywhere: at parties, lingering in dining halls, showing up as late night snacks, etc. Also, the pressures to succeed academically and interpersonally is stronger during college than perhaps at any other time of life. From first-year women undergoing the transition to independent living to seniors negotiating the pressures of career selection, job hunting and financial independence, unique and intense stressors occur throughout the college years.

Preliminary data also indicate that female athletes, because of their tendency to engage in crash dieting and other quick weight loss techniques, are at increased risk for developing eating disorders (Eating Disorders Awareness and Prevention, Inc., 1994). While women constitute the majority (90-95%) of eating disorder cases, there has been an increase in the number of eating disorders that mental health professionals diagnose in men. However, there is evidence to suggest that females are more prone to eating disorders than males because the personality characteristics underlying eating disorders (e.g., perfectionism, obsessive-compulsiveness, depression and anxiety) are more commonly found in women. These characteristics are probably passed down from generation to generation, from mother to daughter.

While there are certain physiological and psychological derivations of eating disorders, unhealthy body image, born out of a relentless mass media campaign and reinforced by unforgiving cultural messages, plays a significant role in exacerbating eating disorders at best and promulgating them at worst. Our society places tremendous pressure on young girls and women to be thin, and strong cultural messages say that thin is better (Levine, 1987). For example, Kate Moss, model, is 5'7" and weighs only 100 lbs. American social mores derive women's worth and femininity in how good they look, and suggest that a woman with the perfect body and face will not have any problems in life (Wolf, 1991). While it is difficult to say that this cultural context

causes eating disorders, it certainly serves to promulgate and maintain women's poor body image and obsession with weight.

Etiology of Eating Disorders. Several studies point to dieting as the most common and most predictable cause of eating disorders. Since the U.S. has become a relatively wealthy nation and many of its citizens have the ability to eat whatever and whenever they want, many individuals can now choose **not** to eat. Eating disorders are a problem of affluence and consequently a rare condition in societies where people are starving and don't know when they will eat again. Eating disorders only appear to be a problem in countries where people are well fed.

What begins as an innocent attempt to lose weight can result in a serious eating disorder. Studies show that 80% of teenage girls and 60% of adult women are what we call disordered eaters, while 10% have eating disorders. There is a fine line between them. *Disordered eaters* fear weight gain, think about what they weigh as well as what they will and will not allow themselves to eat on a daily basis, and practice any of the following weight-loss attempts: on again-off again dieting, skipping meals, 24-hour fasts, diet pills, excessive exercise, diuretics, laxatives, or vomiting (Waterhouse, 1996).

Among most segments in the United States female population, the pressures to be thin lead to dieting. The double standard regarding sexual activity has been revamped in the 1990's into gender-based norms about eating. A quick glance at commercials for fast food restaurants, snack foods. and food in general indicates that guys are allowed to eat all they want, when they want, but women must restrain. Women must constantly be "dieting." In fact, women who overindulge are considered unfeminine, out of control, sinful, immoral. The old adage that "good girls do and bad girls don't" is as equally true of sex as it is for food when it comes to our society's judgment of women. In fact, one of the authors has clients who report that their boyfriends question her professional expertise when they observe their girlfriends following the nutritionist's advice and actually eating breakfast, lunch, dinner **and** snacks.

In a 1985 survey, 90% of respondents thought they weighed too much. On any given day, 25% of women are on diets, with 50% finishing, breaking or starting one. Fat is a source of sexuality and reproductive ability in women, yet 20% of women who exercise to shape their bodies have menstrual irregularities and diminished fertility (Wolf, 1991).

Dieting has become a ritual for females. Since 1960 (after the birth of the dieting industry), female dieting has increased by 300%; girls dieting has increased 1300%. Four out of five women diet (as do one out of four men). Girls are beginning to diet at younger and younger ages. Our mothers probably started dieting during their 30's (in the 60's), when they actually became slightly overweight. The current generation of women most likely began dieting in our teens, while girls today start dieting before they are 10 years old (Waterhouse, 1996).

Consider the following statistics:

- By age 6, 40% of girls express a desire to be thinner.
- By age 8, 50% have tried a diet.
- By age 13, 80% of adolescent girls are dieting to fight the natural changes of their

maturing bodies.

- By age 15, one in eight are chronic dieters.
- By age 16, 45% are crash dieting, 40% are fasting and 15% are taking diet pills.
- By age 17, 4 out of 5 healthy weight young women think they are too fat.
- By age 20, 95% express a strong desire to lose weight.

In 1987 Dr. Drewnowski of the University of Michigan School of Public Health identified three factors which contribute to early dieting: maturation, money, mother. Girls who mature before the age of 12 tend to be heavier than average and may have an increased risk of developing an eating disorder. Children of wealthy parents are inclined to be more anxious about body image and dieting than children on of lower SES. He also found half of all dieting girls were encouraged to do so by their mothers.

Diet clinics, weight-loss best-seller books, and the sugar-free, fat-free food industry boom are artifacts of our society's obsession with dieting. Prescription drugs for weight control have increased 6000% in one year, while 85,000 prescriptions for weight loss medications are written each week (15 May 1997, **NPR**, "All Things Considered"). Yet, all this dieting has not led to Americans losing weight: the rate of obesity is skyrocketing in this country (to 1 in 3 individuals from 1 in 4). (Note that New Orleans, Louisiana tops the list of the most obese cities at 37.55% of its population. This is 4% more than the second-ranked city, Norfolk, Virginia.) Clearly, dieting has backfired. The average woman eats about 200 calories less and weighs about eight pounds more than she did 30 years ago. Similarly, the typical woman may have lost 100 pounds through dieting, but she gains 125 back (Waterhouse, 1996).

Sexual Violence and Body Image

Body image is intimately connected with issues of violence against women, affecting both women's risks for being violated as well as impacting their ability to heal and recover from experiences of sexual violence. As we discussed above, an inherent aspect of the beauty myth is the objectification of women. In addition, the beauty myth places women in an indefensible "Catch 22" -- to the extent that women must make themselves attractive and physically appealing in order to achieve acceptance and success in U.S. society, she is also held accountable for her own sexual victimization based on her appearance. This mixed message impedes women's ability to assert their sexual boundaries — largely because they do not know what they really are — and more often than not cripples their ability to recognize rape for what it truly is: a violation of their physical, sexual and emotional boundaries.

Violence Against Women. A study by Lenore Walker, Ed.D. (1979) indicates that half of all women will be physically hurt by an intimate partner at least once in her lifetime. Sadly, one third of all women with injuries who enter a hospital emergency room are the victims of deliberate, pre-meditated acts of violence committed by intimate partners. In fact, battering by a male partner accounts for more female injuries requiring medical attention than rapes,

automobile accidents and muggings combined. An estimated 25-30% of pregnant women have experienced physical abuse just prior to and during pregnancy. Alarmingly, 30% of all female homicide victims were killed by husbands, boyfriends, ex-husbands, or ex-boyfriends.

Rape is the most rapidly growing, most under reported, and most rarely convicted crime in the world. U.S. women are eight times more likely to be sexually assaulted than Western European women, and 26 times more likely than Japanese women to be raped (Senate Judiciary Committee Report on Sexual Assault, 1991). The F.B.I. estimates that one in three women in this country will be sexually assaulted in her lifetime. In the majority (75-95%) of rape cases, the perpetrator is someone the victim knows – a boyfriend, husband, classmate, coworker, neighbor, brother, father, or uncle. Note that Dianna Russell (1988) found that 25-60% of male students surveyed admitted they would rape a woman if they thought they could get away with it. Similarly, in the **Ms.** Magazine Campus Project on Sexual Assault sponsored by the National Institute of Mental Health, Project Director Mary Koss, Ph.D., found that one in 12 college males surveyed had committed acts which meet the legal definition of rape (forced sexual intercourse) (Koss, et.al, 1987).

Rape Trauma Syndrome. For the victim, rape entails a loss of control and a violation of her sexual and personal boundaries — having tremendous impact on her body image. A variety of short- and long-term mental health problems commonly arise as sequelae to a sexual assault experience, referred to as *rape trauma syndrome*, or RTS. RTS may either follow the sexual assault itself, or arise when the survivor first remembers or comes out of denial about sexual abuse or rape. During the short-term, or acute, phase the survivor attempts to absorb the immediate shock and aftermath of the attack. This typically lasts from two weeks to a year. The long-term phase follows, during which the survivor attempts to cognitively accommodate the experience; this is a lifelong process and may entail many changes in lifestyle and alterations in self- and other-perception. RTS is very similar to the post-traumatic stress disorders (PTSD) identified in veterans of war, the criteria for which are outlined in the **DSM-IV** of the American Psychiatric Association (1994).

The impact of rape on women's mental health has been demonstrated by several researchers to be a devastating one. Following a two-year study at Boston City Hospital, Burgess & Holmstrom (1979) found that women who have been raped experience immediate emotions ranging from fear, mistrust, and anger to shock and withdrawal, of which fear is the most salient: fear of injury or death during the attack, fear of another attack, fear of people who look like the attacker, etc. As time elapses, nightmares, anxiety, changes in lifestyle and relationships, as well as disturbances in sleeping, eating and sexual habits frequently occur (Burgess & Holmstrom, 1979). Undoubtedly, however, the predominant feelings among women who have been raped are guilt and self-blame, feelings which recur for many years (Burgess & Holmstrom, 1979; Gidycz & Koss, 1991; Burkhart, 1991). Survivors erroneously believe they deserved to be raped, that they could somehow have prevented the rape or abuse if they had dressed or behaved differently, been sober or chaperoned, or been a better daughter, girlfriend or wife.

Scores on trait inventories demonstrate that rape victims are significantly ($P < .01$) more depressed, anxious and fearful than nonabused matched controls, regardless of the number of

years that have elapsed since the attack (Santiago, 1985). In a nation-wide sample which included 3,187 undergraduate women, 30% of the women identified by the survey as rape victims contemplated suicide after the incident (Warshaw, 1988). Similarly, a 1984 study by the National Institute of Mental Health found that victims are, compared with victims, three times more likely to suffer a nervous breakdown and five times as likely to attempt suicide (Heires, 1991).

Oftentimes accused by society, the system, their significant others, and by themselves for somehow provoking the rape, survivors are caught in a dangerous circle of self-destruction and self-blame. Thus, suffering in silence, they refrain from reporting the crime and are hesitant to tell friends or family -- oftentimes withdrawing from them. Approximately 40% of college women who were raped told no one about their assaults (Warshaw, 1988). The F.B.I. Uniform Crime Reports (1989) estimates that only one in ten rapes are ever reported to the police; this estimate is corroborated by the National Victim Center. A rape survivor may even end a relationship with an unsupportive partner a recent study by the National Institute of Mental Health indicates that about half of 40 women studied broke up with their spouse or partner within four years (Heires, 1991). Some survivors are forced to leave school or quit their jobs in order to avoid curious or harassing peers (Warshaw, 1988; Gidycz & Koss, 1991).

Coping With and Recovering From Sexual Violence. In an effort to accommodate the rape into her life events, a woman utilize coping strategies -- actions, behaviors and thoughts that enable her to deal with a crisis situation -- some of which are health and constructive, while others are self-destructive. Denial of one form or another -- that is, failure to identity an attack as rape, of failure to acknowledge or remember abuse even occurred -- is perhaps the most common coping mechanism adopted by rape and incest survivors (Burgess & Holmstrom, 1979). The fear of being blamed or disbelieved is difficult to overcome, and unfortunately, many survivors do have an environment in which they feel safe enough to come out of denial about their rape. Other survivors do not possess enough awareness to even realize that they were raped: the societal definitions are vague at best and legal definitions are inadequate. In addition, women are socialized just as men are to believe the many rape myths that serve to place blame on the victim. As a result, in a national college-age sample, only 27% of the women who sexual assault met the legal definition of rape identified themselves as rape victims (Warshaw, 1988). Survivors who are in denial sleep excessively, abuse food, use alcohol and other drugs, or engage in sexual activity -- usually unprotected -- with multiple partners to "make the rape go away" and to avoid confronting the distributing memories, thoughts and feelings associated with the rape (Bass & Davis, 1988; Burt & Katz, 1988).

Socioeconomically disadvantaged women and minority women in particular are often unaware of or do not have access to supportive networks and treatment services. Black, Asian, and Hispanic women are more likely than white women to be assaulted (Amir, 1971) but less likely to be believed by the police and the courts. Similarly, younger women are less likely to be aware of or utilize mental health services, yet women 13-18 years old experience the highest rates of sexual assault and incur a risk four times greater than at any other point in their lifetime (Warshaw, 1988).

Based on their extensive individual and group counseling experiences with survivors of

childhood sexual assault, Bass & Davis (1988) believe that a woman's relationship with her entire body, including how she breathes, how she eats, and how she experiences pain, is deeply affected by childhood sexual abuse. As a child, the body is the means by which one learns about trust, intimacy, protection and nourishment. When a child is abused however, she learns that the world is not a safe place in which to get her needs met. Splitting, numbing, addictions, and self-mutilation — to name a few problems that survivors have with their bodies — become strategies by which children coped with the abuse and survived.

Because sexual abuse is perpetrated on one's body, say Bass & Davis, many survivors blame themselves for responding, for being attractive, for being womanly, for being small, for being large, for being vulnerable, for being susceptible to stimulation and pleasure, even for feeling anything. Therefore, learning to love her body becomes a major aspect of healing from sexual abuse for the survivor. Tasks to tackle include: moving from splitting to being in her body, from numbness to feeling pain and pleasure, from ignoring her body to listening to her body, from physical illness to a healthier body, from addiction to freedom, from self-mutilation to self-care, from victim to victor, becoming a nourishing eater, incorporating exercise, and overcoming insomnia.

Eating Disorders and Denial. The prevalence of rape in the U.S. and the high rate of denial among victims suggest that a substantial number of American women are undergoing a tremendous amount of emotional anguish and psychological trauma but failing to seek help. Rather, they are self-medicating with alcohol or other drugs, food, and other abusive behaviors, effectively inhibiting their ability to freely pursue productive or satisfying studies, careers relationships and lives. The connection between a history of sexual assault and a pattern of alcohol or other drug abuse, although infrequently the focus of formal research, is one that is well-documented by clinicians and other mental health professionals who work with incest and rape survivors.

It is important to keep in mind that much of the research heretofore conducted on the relationship between sexual assault, substance abuse and eating disorders is not in keeping with the statistical or methodological standards of epidemiology. Few of the studies mentioned are population-based or truly experimentally controlled, and samples are frequently biased by self-selection. The observations that have been made in the field are not as scientifically laudable in their conclusions as they are in clearly framing that a problem exists.

During the 1980's several pilot studies have estimated that 30-75% of adult women in treatment for substance abuse disorders are survivors of rape or child sexual assault, whether the woman is abusing alcohol, other drugs or food (Rohsenow, et.al., 1988; Root & Fallon, 1988). Such numbers indicate that substance abuse and sexual abuse histories are somewhat correlated. Based on such data and her own clinical observations, Root (1989) pinpointed sexual assault as a common denominator among female clients who were resistant to substance abuse treatment, or who have been identified as having an "addictive personality," referring to the tendency to replace one addiction with another. In a sample of 158 British women who presented with a clinical eating disorder, about a third reported sexual experiences with an adult before the aged of 16 (Palmer, et.al., 1990). The correlation between sexual assault and substance abuse is

especially pronounced among adolescent girls and children. Of all teenaged girls who entered the Chemical Dependency Treatment Program at the Mid-Maine Medical Center, 71-90% disclosed histories of child sexual abuse upon routine inquiry, suggesting that unresolved issues from abuse may be a hidden factor underlying the substance abuse (Rohsenow, et.al., 1988). A survey of 597 adolescent girls being treated for substance abuse in nine inpatient facilities across five states yielded 35% who had been sexually abused (Edwall, et.al., 1990).

Research also demonstrates that adolescent girls who have been incested or sexually abused use more alcohol and marijuana compared to national and local adolescents' use patterns. They begin to use substances at an earlier age, and are more likely to be classified as moderate to heavy drinkers than other adolescents (Flanigan, et.al., 1988). In a 1988 Seattle, Washington study of 369 sexually abused children, 76% of whom were female, Conte (1988) discovered that these children had a higher prevalence of eating disorders, alcohol abuse and drug abuse as compared to non abused children residing in the same city. From such statistics, Singer and colleagues (1989) speculate that children's use of mood-altering drugs is a coping strategy, that the effects of mood-altering substances may help satisfy some of the interpersonal needs of childhood sexual assault survivors, enhance self-esteem and ameliorate feelings of isolation.

Burt & Katz (1988) conducted a study on 113 adult female rape survivors in the Washington-Baltimore area. Their questionnaire tool described 33 coping behaviors which subjects rated on as even-point frequency scale (1 = never, 7 = always). Subjects were asked to mark responses for how they dealt with the rape immediately afterwards and how they were dealing with the rape at the time of the interview. A factor analysis yielded five scales: (1) Avoidance; (2) Expressive; (3) Nervous/Anxious; (4) Cognitive; and (5) Self-Destructive. Avoidance behaviors included excessive sleeping and trying not to think about the rape. Expressive survivors talked about and vented their feelings, sought counseling and support from friends. Nervous/anxious survivors ate or smoked cigarettes considerably more than usual, and took prescription drugs such as Valium to help relax. Survivors who adopted a cognitive approach attempted to reconceptualize and "make sense" of what had happened d to them, while self-destructive survivors, in addition to taking a lot of physical and emotional risks, consumed a lot of alcohol, took other drugs, binged, and smoked cigarettes much more than usual.

From extensive work with their clients, therapists Bass & Davis (1988). observed that drinking and taking drugs provide incest survivors a way to escape pain, to find relief, to protect oneself, to regain control and to feel better. Many incest survivors are addicted to alcohol and drugs precisely because these substances are effective ways to numb feelings and suppress memories. Through substance abuse, adds Root (1989), a rape survivor can sufficiently compartmentalize internal experiences in order to function in daily life. The mitigating role served by substance abuse reinforces itself because the survivor is able to avoid and suppress emotions and memories related to the trauma, thus making it difficult for her to stop abusing substances.

Substance abuse also numbs the frustration and confusion for survivors struggling with issues of intimacy and sexuality. Following a rape, a woman may feel "dirty" or like "used goods" (Warshaw, 1988; Burgess & Holmstrom, 1979). A pregnancy, abortion or sexually

transmitted disease may have ensued from an attack. A violent rape may result in serious injuries or require operating on the vagina. Because of flashbacks, survivors frequently avoid sex for weeks to month after an assault, which may create fiction with her sexual partner (Warshaw, 1988; Adams & Fay, 1989). Rape and incest substantially alter the meaning of sex and intimacy for most survivors; sexual intercourse oftentimes becomes equated with violence, pain, humiliation and secretiveness (Bass & Davis, 1988; Maltz, 1991). No wonder than that for many survivors, sexual problems such as diminished arousal and interest, or inability to achieve orgasm commonly arise, considerably dampening the pleasure of sexual activity (Adams & Fay, 1989; Maltz, 1991; Finney, 1990). For survivors, the tension of sexual problems is more easily soothed with alcohol or other drugs.

Substance Abuse and Body Image

Research on women and substance abuse, in particular alcoholism, has emerged as an important area of inquiry during the past decade. As the previous section indicates, substance abuse is related to issue of sexual violence; however, substance abuse is also directly affiliated with women's feelings and perceptions about their bodies and self-worth. Poor body image may result in depression, which leads to substance abuse. Or, anxiety or ambivalence about her sexuality and femininity may increase a woman's likelihood of abusing substances. Practitioners know that abuse of alcohol and other drugs often accompanies bulimia. Young girls trying to control weight are the group mos likely to begin smoking -- suggesting that in order to effectively implement smoking cessation programs with women, health educators must first address body image.

Women and Alcohol. Despite estimates that anywhere from 25-50% of all alcoholics are women (Kinney & Leaton, 1983) relatively little research focuses specifically on women's drinking patterns. Alcoholic women are more likely than alcohol men to attribute the onset of problem drinking to a particular traumatic incident (Blume, 1986). In fact, Sandmaier (1980) found that a third of the women she interviewed cited a significant life event or crisis that triggered the onset of drinking, while only one in eight men cited such a crisis. Some of the specific triggers reported by women include divorce, gynecological operations, postpartum depression, infidelity and menopause (Kinney & Leaton, 1983). Such events cause a woman to seriously reconsider her identity, roles and adequacy as a woman. A recent rape or coming out of denial about past childhood sexual assault, while not included in the above list, would be logical additions.

In a 1981 national sample of women drinkers, Wilsnack, et.al. (1991) found that sexual dysfunction was the single best predictor of problem drinking; this finding may reflect women's tendency to self-medicate sexual difficulties with alcohol, given predominating societal beliefs that drinking reduces sexual inhibitions and facilitates sexual pleasure.

Women's drinking differs from men's not only in onset, but in frequency and amounts as well. In general, women are more susceptible to alcohol's intoxicating effects and to the physiological effects of heavy drinking. They possess less *alcohol dehydrogenase*, the enzyme

which breaks down alcohol, and they have less total body water (45-55%) as compared to men (55-65%) with which to dilute the alcohol.

As a result, Wechsler, et.al. (1995) defined binge drinking as four drinks in a row for women (as opposed to five drinks for men), reflecting the fact that the problem consequences of drinking (e.g., unplanned sexual activity, missing class, driving while intoxicated occurred after consuming lesser amounts of alcohol by women as compared to men. However, women were considerably less likely to damage property or get in trouble with campus police after binging. Just over half (56%) of a national sample of 10,203 college women surveyed were binge drinkers, and 28% binged frequently (binged three or more times in the past two weeks) (Wechsler, et.al., 1994). Furthermore, women are much more vulnerable than men to the negative health effects of prolonged, heavy drinking, such as cardiovascular disease and cirrhosis of the liver (Blume, 1986).

One in 10 women leave their alcoholic husbands; one in 10 men stay with their alcoholic wives. Women experience greater stigmatization for their alcohol use. In addition, women who drink heavily incur a negative perception as being more sexually available or promiscuous, and of being less in control.

Women are heavily targeted for the marketing of alcoholic beverages. Women spent $40 billion on alcohol in 1994, compared to $20 billion a decade earlier; they consumer almost 68% of all wine coolers (NCADD, 1990). Hispanic and black women report higher abstinence rates than white women, but with acculturation, abstinence rates among Hispanic women drop significantly. Native American women between the ages of 15-34 are 36 times more likely (and black women six times more likely) than white women to have cirrhosis of the liver (NCADD, 1990).

College Women and Drinking. Physiological, environmental, psychological and situations factors play a role in explaining both men's and women's problem drinking, but relationship issues seem to be particularly important for women during the college years, when developing relationship is especially valued. Women often start drinking as the best they know to be with others, relax in social situations and support and be a part of the peer culture. That may start as drinking to combat shyness, join with others or be part of the crowd, be liked and acknowledged, attract and be with either men or women, or reduce inhibitions can provide opportunities for trouble. Alcohol softens the pain of failure in any of these areas — the sense that one cannot meet the expectations of others, and of oneself, and that one lacks the capacity to enter into satisfying relationships. To compound the problem women face special risks in crossing the line from social to problem drinking, at which point they become stigmatized, especially when they become potential victims of physical or sexual assault. Traumatic events, including violence, frequently lead women to further withdrawal, isolation, depression, and increases vulnerability to alcohol (Gleason, 1994).

Tobacco. Over 15% of women smoke cigarettes daily, as compared to only 9% of men. Young girls are also initiating cigarette smoking at rates which surpass of their male peers. Cigarettes are targeted deliberately by the tobacco industry in their advertising. Themes used to

entice women include sophistication, professional success, perfectionism, control, appetite suppression, and weight loss (Kilbourne, 1985). More recently, cigar smoking has risen dramatically among college and professional women.

Other Drugs. Even less research has been conducted on the etiology of women's drug abuse. However, the patterns of onset are similar to those of problem drinking. Researchers do know that women are more likely than men to use alcohol in conjunction with other drug such as tranquilizers, sedative and amphetamines, resulting in a high possibility of cross-addiction (Blume, 1986). Mood altering drugs are prescribed much more frequently to women than to men. In fact, 60% of tranquilizers (of which Valium is the most common one), 71% of all antidepressants and 80% of all amphetamines are prescribed for women. Nearly 26% of girls ages 12-17, compared to nearly 24% of boys, have used an illicit drug.

Gay Women. Studies by the National Institute of Mental Health indicate that gay men and women are four times as likely to abuse alcohol as their heterosexual counterparts. Coping with society's homophobia, as well as the stress of "coming out"to friends, family and coworkers (or conversely the anxiety associated with "remaining in the closet") are likely to be contributing factors. In addition, this statistic becomes increasingly meaningful when we consider the higher-than-expected number of survivors of childhood sexual assault and incest that are frequently reported among lesbian populations. Clearly, this is an area which substantially more research.

Depression, Anxiety and Body Image

From the discussion above, we have already seen the interconnectedness of body image, self-esteem and depression. Depression frequently accompanies anorexia and bulimia, is present in survivors of sexual violence, and is typically associated with substance abuse among women. While nearly half of men score high on self-esteem tests, only one third of women do. About one third of women want an overhaul of their entire appearance, and 99% of women want to change something about their appearance. Women are more likely than men to become clinically depressed. Women attempt suicide three times as often as men do.

In her book **When Feeling Bad Is Good**, Ellen McGrath has talked about the depression experienced by women as a result of personal, social and health challenges they confront everyday in their lives:

1. *Victimization Depression* from the emotional, economic, physical and sexual abuse targeted at women.
2. *Relationship Depression* from poor quality or quantity in a woman's relationships.
3. *Age-Rage Depression* from cultural devaluation and restriction of activity because of aging.
4. *Depletion Depression* from the energy drain from women's typical role overload and role conflict.
5. *Body-Image Depression* from impossible standards of physical perfection imposed

on women.

6. *Mind-Body Depression* from the physical illness caused by depressions, and the depression caused by physical illness.

Sexuality and Body Image

Body image is not typically addressed by health professionals when providing sexual health promotion or reproductive health information, even though it is a belief of the authors that women's poor body image, as well as the subsequent lowered self-esteem and self-consciousness have serious ramifications on women's ability to practice sexual and reproductive health. For example, a woman who is uncomfortable with her body may not feel comfortable inserting a diaphragm by herself. Similarly, women who are extremely concerned about weight gain may resist taking oral contraceptives for fear of one of its possible side effects. It is no accident that Twiggy appeared in the pages of Vogue magazine in 1965, simultaneously with the advent of the birth control pill, in an attempt to allay concerns about one of the pill's most undesirable side effects. One of the authors has found that a man women who are taking oral contraceptive continue to smoke cigarettes, despite the fact that smoking is a major contraindication to pill use.

Most importantly, women's poor self-esteem and concern about body image interferes with their ability to fully experience or connect with their sexual selves. Women's reproductive health and sexual health depend so much on their overall physical and psychological health. Premenstrual syndrome is fraught with anxiety for women, in large part because women are taught to deny and actively fight against the many symptoms which naturally occur: water gain, mood swings, breast tenderness, etc. Menopause generates similar anxieties for women, as their bodies change and women's lose the ability to reproduce.

Clearly, a healthy self-concept and positive body image are essential to healthy sexuality, as well. One of the most important tasks facing women is to begin regarding their sexuality subjectively, rather than objectively as is universally the case in mass media and many cultural norms. Furthermore, by reclaiming definitions of female sexuality, women will take a major first step towards redefining women's worth and women's body image.

Sexualityinvolves more than just genital sexual activity. According to the Advocates for Youth (formerly the Center for Population Options) in their publication A Youth Leader's Guide to Building Cultural Competence (1994), sexuality encompasses five major components: *sensuality*, *sexual intimacy*, *sexual identity*, *reproduction/sexual health*, and *sexualization*.

1. Sensuality is what enables people to feel good about how their bodies look and feel. It allows them to enjoy the pleasure their bodies can give to them and others. The need to be touched by others in loving ways, the feeling of physical attraction for another person, body image, and fantasy are all part of sensuality.

2. Sexual intimacy is the ability and the need to be emotionally close with another and

to have that closeness returned. While sensuality refers more to physical aspects of our relationships, sexual intimacy focuses on emotional needs.

3. Sexual identity refers to people's understanding of who they are sexually, including

   a. *gender identity* (their sense of being male or female);
   b. their *gender role* (what men and what women are supposed to do); and
   c. their *sexual orientation* (which sex or sexes they have primary affectional and sexual attraction to).

4. Reproduction and sexual health is the most familiar aspect of sexuality. It includes all the behaviors and attitudes having to do with having healthy sexual relationships and having the ability to bear children.

5. Sexualization is using sex to influence, manipulate or control other people. Termed the "shadow" side of sexuality, sexualization spans behaviors that range from mutually enjoyable to harmlessly manipulative to violent and illegal. It includes such behaviors as flirting, seduction, withholding sex, sexual harassment, sexual abuse, incest and rape.

Sex researcher Alfred Kinsey (1948) found that religious beliefs and guilt had little or no effect on men's sexual pleasure, but it greatly interfered with a woman's enjoyment of sex, undermining with guilt and shame any pleasure she might otherwise experience. In general, the sexual double standard has required women to deny their own sexuality — equating women's sexuality temptation and sin, yet women are also asked to be sexually desirable in order to be feminine.

More than 80 percent of individuals in the U.S. first have sexual intercourse as teenagers; more than half of females and almost three-quarters of males aged 15-19 have had sexual intercourse (The Alan Guttmacher Institute, 1994). By the time they enter college, about 75% of women have become sexually active.

One in four sexually active women ages 16-25 will contract a sexually transmitted disease. The number of AIDS cases is increasing four times faster among women than among men. Women are 12 times as likely as men to contract HIV and four times as likely to contract an STD from vaginal intercourse. One in 10 young women become pregnant each year. The U.S. has the highest rate of teen pregnancy in the industrialized world. Caesarian sections are the most frequently performed major surgery in the U.S. Hysterectomies are the second.

Practice Implication #1: *Foster body acceptance (self) and body appreciation (others).*

Differential treatment of individuals based on their size remains the last socially acceptable form of discrimination in our society. The fashion industry and the media continually portray limiting and narrow definitions of beauty and attractiveness. Women expend considerable -- sometimes exorbitant -- amounts of energy and money to achieve an impossible ideal of physical perfection. These are human resources that could be better directed towards fostering size acceptance and self-love.

As campus health educators, our mission is to empower women in re-developing healthy body image. It may appear as if we are fighting an uphill battle since so many forces exist at colleges and universities to reinforce unhealthy body images for women: pageants, Greek-letter social organizations and other cocurricular activities which foster competition among women on the basis of appearance; student recreational centers — perhaps even student health centers — which inadvertently perpetuate health-related myths and unrealistic standards; experimentation, with sexual relationships, alcohol and other drugs, etc.; and on-campus media, including the student newspaper,, print advertising, and local billboards.

It is imperative that we generate a new culture that regards people of all shapes, sizes and colors as beautiful and deserving of respect. We need to shed the assumptions and moral judgments we typically make in relation to someone's size (e.g., thin is good because it demonstrates self-discipline, fat is bad because it represents overindulgence). These stereotypes only serve to hurt and divide individuals. Rather, let us begin teaching children and young adults to nurture their inner souls and appreciate their outer bodies. Consider the following *Bill of Female Food Rights* (Waterhouse, 1996):

1. Freedom of Food Preferences
2. Freedom of Food Choices
3. Freedom of Meal Times
4. The Right to Bear Hips and Thighs
5. The Right to Peacefully Assemble for a Meal
6. The Right to Be Free From Unreasonable Scrutiny and Suffering with Food
7. The Right to Eat What We Want in Public
8. The Right to Eat Ice Cream for Dinner
9. The Right to Dislike Broccoli
10. The Right to Not Have Perfect Eating and Exercise Habits

In moving towards a healthier body image, health educators must first examine their own preconceptions about weight and their own eating issues, so they don't perpetuate unhealthy behaviors. Only then can we can help our students to:

- **Quit dieting.** As health educators, we must remember that "ideal weight" is an abstract rather than absolute concept. In fact, height-weight tables are merely gross estimates, and frequently use limited populations. We must use these tables with caution, and instead focus on total health at every size. We must move away from "diets" to self-caring behaviors. This doesn't mean that we shun all weight loss efforts; clearly, obesity and overweight pose serious health risks. Rather, the

latest position of the American Dietetic Association posits that: "successful weight management for adults requires a life-long commitment that is sustainable and enjoyable."

- **Learn to express themselves.** In eating disorders prevention and treatment, we ask students to speak the language of words, instead of using body language. They must give up old modes of coping, which will need to be mourned. They should be given the space to vent the tears, anger, guilt, self-doubt and pain in words instead of food rituals, asceticism, and other psychosomatic problems.
- **Align body and mind.** Many women no longer know how to listen to their bodies. Hunger pangs have been denied, needs for intimacy have remained unmet, cramps and water gain associated with menstruation are medicated away, and the pain of sexual violation is numbed with alcohol. Many college women deny themselves sleep in order to make more time to meet the never-ending demands of being a "superwoman." Exercise has become an excursion into self-imposed punishment for overindulging, rather than an effort at healing and strengthening the body. Each woman must re-learn how to tune into her body's messages: eat when hungry, cry out when in pain, reach out when in need.
- **Build self-esteem.** Minimize beauty-focused messages. Encourage clients to compliment themselves. Teach them how to turn off the "critical inner voice" and instead engage in "positive self talk," particularly when it comes to size, shape and appearance. Help students respect their bodies. Encourage them to purchase clothing which makes them feel good, rather than being a slave to trendy fashion.

- **Make peace with their bodies.** Health educators can encourage students to give positive feedback to their peers, telling them they look good the way they are. They can show TV ads and examples of print media in educational programs and discuss the ways unrealistic body images are used to sell products, as well as talk about what their personal and reachable, health-based body image development might look like. Encourage the inclusion of exercise which is enjoyable and rewarding — rather than punitive and painful — as an essential ingredient of total well-being. Stress the importance of seeking support or counseling for issues such as substance abuse, sexual assault, depression, etc.

Educational workshops about body image, and its relationship to sexuality and intimacy can be accomplished by utilizing the following discussion questions from Advocates for Youth (1994) The questions are ideal in their consideration of family upbringing and cultural differences:

(1) What do you consider to be the "ideal" body types for a man and for a woman? What do members of your family think? How are your ideals influenced by your upbringing and images in mainstream advertising? Are you generally happy with your body? Do you think your view is atypical of those around you?

(2) In what ways do you express different levels of intimacy? Do you think you have different needs for intimacy than most members of the opposite sex? Do you consider displays of affection acceptable or in poor taste?

(3) How do you express closeness to members of the same sex? To friends of the same or opposite sex?

(4) When and how were you allowed to date? Was dating in the conventional American sense the norm for your household? Were you allowed to socialize in co-ed groups? Were there any specific restrictions or unspoken rules about these activities?

(5) Which gender was encouraged or expected to take the initiative in heterosexual romantic relationships? Who was supposed to ask first? What expectations were there for the opposite sex in response?

(6) Are some sexual acts taboo? If so, which ones and with whom? When? How do you view masturbation? Have your responses changed from your childhood and adolescence? If so, how?

(7) If you have had heterosexual intercourse, at what point was contraception a part of your sexual experience? Your sexual education? How was the subject treated in you family? Who was responsible for purchasing and using contraception, including condoms?

(8) How do you view homosexuality? How does your view influence or not influence your treatment of others? Your own behavior?

(9) Are gay, lesbian and bisexual people accepted as members of your community? The community you were raised in?

(10) Are you gay, lesbian or bisexual? When did you come out to yourself? Are you out to friends? Family? Employers and co-workers? Why or why not? How many other members of the gay, lesbian or bisexual community do you know? How involved are you in organized gay, lesbian or bisexual community activities?

(11) What behavior constitutes flirting? What are your expectations of people engaging in flirtatious behavior? Are their certain behaviors that are unacceptable?

(12) At what age did you first express yourself physically in a sexual relationships? Was that considered an acceptable age by your family for someone of your gender? Was it typical of your peers? What age was considered acceptable for males to have sexual intercourse? For females?

(13) What did you learn about child sexual abuse growing up? About forced sex between partners? About sexual harassment? How is that knowledge different or similar to what you know now?

Practice Implication #2: *Provide assertiveness training.*

Sex-Role Socialization. *Sex-role socialization* refers to the process by which men and women are taught by their parents, peers, teachers, the media, etc. about gender-appropriate behaviors. This posits that concepts masculine and feminine behavior are culturally derived and learned concepts, as opposed to inherent or genetically determined. The end result of differing patterns of socialization for females and males is that boys develop "wings," which allow leaving the nest, exploring far reaches, testing boundaries, and "flying alone," whereas girls acquire "roots" which anchor, stabilize and facilitate growth, but allow fewer opportunities to master the

environment (Block, 1984, as cited by Lips, 1989).

Numerous studies have shown that gender stereotyping tends to be stronger, and that demands placed on girls are more restrictive, in working-class families as compared to middle-class families (Mc Broom, 1981; Rubin, 1976; Romer & Cherry, 1980, as cited by Lips, 1989). Studies of both Mexican-American and Puerto Rican families suggest that these ethnic groups emphasize the wife-mother role for women more heavily than in non-Hispanic white families (Mirande, 1977; Fitzpatrick, 1971, as cited by Lips, 1989). In general, research of African American families suggests that they are less likely than are white families to polarize behavioral or role expectations based on gender (Lewis, 1975; Reid, 1985; Romer & Cherry, 1980, as cited by Lips, 1989). For instance, black children tend to regard men and women as being equally emotionally expressive, and girls in black families are more often socialized toward a female role that is defined as one of strength, independence, and resourcefulness, rather than of weakness (Reid, 1985, as cited by Lips, 1989). Among Asian Americans, girls and boys are brought up with traditional sex-role expectations which are exacerbated by the cultural norm of male superiority and system of patriarchy (Hong & Hong, 1995).

The process of sex-role socialization has serious ramifications on women's body image and eating habits. Rather than being allowed to freely express the entire range of feelings that all individuals experience, women must frequently subvert feelings of anger (or risk being labeled a "bitch" or accused of being on PMS) and dependence (for fear of being rejected). In addition, man women are taught to allow others to set boundaries for them, both physical and emotional ones, making personal boundary setting a difficult challenge.

Emotional Management and Control. In an era when women's roles are rapidly changing, women receive conflicting messages about how they should behave in the home, school or workplace, as well as in relationships and as individuals. As a result, the ability to manipulate and control what they do or do not eat is a comforting method of alleviating the feelings of powerlessness and confusion, and especially guilt, betrayal and anger.

Emotional eating refers to the use of food to alleviate negative feelings such as rejection, frustration, anxiety, disappointment, anger, sadness, or fear. Food can temporarily numb feelings and fulfill the need for intimacy and comfort. However, emotional eating results in a vicious cycle in which the temporary state of regaining control through binging or purging is followed by guilt, which only fuels more shame and feelings of failure.

Friends, family, partners, roommates, employers, teachers — all of these individuals are socialized by the same set of cultural norms and expectations as are college women. It is impossible to expect women can successfully heal their body image and being developing an intrinsic sense of self-worth if those close to them continue to hound them about those extra 10 pounds, or threaten to withhold love or affection if they don't lose weight, or even reward them for adhering to beauty standards.

Assertiveness training for women with regard to body image must include skills building in the areas of boundary-setting with significant others, emotional management, decision-making,

communication skills, and cognitive reframing skills. Women must resist the dieting double standard claim the right to eat the foods we like to pleasure our taste buds, to fuel our bodies when they are hungry, to consider eating a morally neutral activity, and to take the guilt out and put enjoyment back in food.

Practice Implication #3: *Replace the competition paradigm of women's relationships with one of campus, local, state, national and worldwide connection.*

Carol Gilligan (1982), in critiquing Lawrence Kohlberg's theory of ethical development (who concluded that women were lacking in this area of development) argues that rather than adhering to a strict standard of "right and wrong," women are committed to a culture of care, tend to see a variety of dimensions and take perspectives that include responsibility for and attending to the interests of all involved. Women look at the context and seek solutions that will benefit others as well as themselves. Women define themselves in terms of connection and relatedness to others, whereas men are rooted in conceptions of self that are characterized by separation and autonomy.

Gilligan's analysis provides insight into what is women's strength. Far too often on campuses, in the workplace, and in social settings, women are asked — indeed, forced — to compete with each other: for grades, for men, for jobs, for attention. Women may even compete on who is best at denying her hunger, withholding food from herself, or losing weight. In this dangerous game, the "best girls" are the ones who can exercise the most control over their own bodies. The competition may be formal and organized, as in a campus beauty pageant, or a contest to see who can lose the most weight before Spring Break and bathing suit season. Or, the competition can be informal — and much more destructive.

Returning to the basis of women's strength will be the key to healing our collective psyches. Through connection, we recognize the ways in which the dieting and denial of some women hurts all women. By uniting, our combined strength and consciousness can combat and challenge the prevailing norms about female beauty and women's worth. Only when women begin to celebrate the diversity of their sizes, shapes, colors and experiences can we began to tear down a beauty myth that reflects no woman's reality.

Eating disorders are rare in societies in which food is scarce. Connecting to our international sisters who face hunger may give women in the U.S. a new perspective on food. Perhaps we will reframe our current relationship with food, one that is based on denial and control, to a healthier one that is based on nurturance, pleasure and freedom.

Practice Implication #4: *Alter and reframe the existing U.S. "women's culture" through activism and advocacy.*

"Women's Culture." Culture can be defined as the body of learned beliefs, traditions, principles and guides for behavior that are commonly shared among members of a particular group. Culture serves as the road map for both perceiving and interacting with the world (Locke, 1992).

The authors argue that a "women's culture" has emerged in the U.S. that is based on distorted views of women's bodies. Women are taught to believe that beauty is the key to success, happiness and true love, and that competition among women — for men, for jobs, as well as for beauty — are normal and inevitable. Dieting, denial and starvation — both physically and psychologically — have become the traditions by which we create women. Vomiting and other forms of purging are the bonds of sisterhood. Femininity is merely the embodiment of principles and guides for behavior deemed appropriate for women. There is even a language which underlies women's culture, e.g., "I feel fat," even though fat is a physical state rather than an emotional one, "I'm so upset I could puke," and "She's so thin — I hate her!," both of which translate literally.

Culture never disappears overnight. Rather, it evolves. But the changes to women's culture that need to take place will not until women acknowledge, name and understand the existing cultural norms which they may not have had a hand in creating, but certainly play a significant role in defining their identity and self-worth. Our role as health educators is to ensure that we do not inadvertently reinforce cultural messages that locate women's self worth in what the scale reads. Furthermore, we must facilitate students' critical analysis of the cultural norms which impinge on their lives, and then arm them with the tools to replace aspects of that culture with ones that celebrate, value and appreciate women.

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DIETING, DATING, AND DENIAL: WHOSE BODY IS IT?
Self-Assessment for Health Educators

I am ***____female*** ***____male***

Circle the number that most closely corresponds to how you feel:

1 - agree strongly
2 - agree
3 - neutral
4 - disagree
5 - disagree strongly

1.	I feel uncomfortable standing naked in front of a full length mirror.	1	2	3	4	5
2.	I often experience feelings of guilt after eating.	1	2	3	4	5
3.	I often "feel fat."	1	2	3	4	5
4.	I often compare myself to others to see if they are heavier than I am.	1	2	3	4	5
5.	I feel uncomfortable engaging in certain activities, such as swimming, because of my weight.	1	2	3	4	5
6.	I believe smoking is an effective means to weight control.	1	2	3	4	5
7.	I experience feelings of guilt if I miss exercise for more than one or two days.	1	2	3	4	5
8.	I am uncomfortable using masturbation as a means to my own pleasure.	1	2	3	4	5
9.	I tend to choose friends with body types similar to my own.	1	2	3	4	5
10.	Achieving a tan is a priority for me each summer.	1	2	3	4	5
11.	When I am feeling depressed, eating certain foods help me to feel better.	1	2	3	4	5
12.	I believe most obese people could lose weight if they followed diet and exercise plans more closely.	1	2	3	4	5
13.	I would find it harder to believe that a woman was raped if she was dressed provocatively and had consumed excessive amounts of alcohol.	1	2	3	4	5
14.	I would be unhappy with my weight if I did not fit into a height/weight chart.	1	2	3	4	5
15.	Sometimes I am unable to relax unless I have one or two drinks.	1	2	3	4	5
16.	I find that trying on clothing in a store is stressful.	1	2	3	4	5
17.	When I undress in front of my sexual partner, I prefer to have the lights off.	1	2	3	4	5

TOTAL ___+___+___+___+___

A high score (85 being the highest) indicates that you are aware of body image issues and have worked to incorporate this knowledge into a positive body image for yourself. A low score (17 being the lowest) indicates that you may have a poor body image. This could have a negative effect on your health.

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